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Two Faces of Emil Kraepelin

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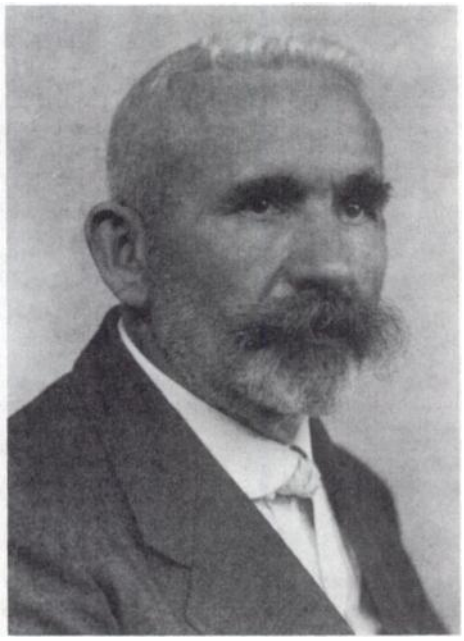
Eponymous lecturers are expected to make some reference to the person in whose name the lecture is being delivered. In this case my task has been facilitated by the fact that the first Mapother lecture was devoted to Edward Mapother himself. It was given by his successor, Sir Aubrey Lewis, who, as was his wont, furnished a comprehensive account of his subject, demonstrating how this remarkable man laid the foundations of the institution to which he devoted his professional life. Lewis's lecture, entitled "Edward Mapother and the Making of the Maudsley Hospital" (Lewis, 1969), provides a link with this one via the mention of the visit paid by Frederick Mott in 1909 to Emil Kraepelin's Forschungsanstalt in Munich, where he was so impressed by what he saw that he resolved to use Henry Maudsley's bequest to found a corresponding institution in this country. Edward Mapother was to assume a major responsibility for this large enterprise which he justified as follows:



Emil Kraepelin, 1856–1926.

> "The only hope for the sort of dispassionate long-term research which psychiatry needs, is the creation of teams of career investigators . . . most of whom should not be primarily psychiatrists at all, but real experts in various branches of science, who have brought its technique to the service of psychiatry and then received enough training in this to enable them to see its problems. . . Then we should get progress, not pot-boiling."

Pot-boiling: Mapother was never shy of calling a spade a spade and, as we now know, his realistic foresight has been amply attested by the development and status of the Institute and the joint hospitals.

Admiring Kraepelin as they did, Maudsley and Mott and Mapother would certainly have wished to do him honour at the special meeting organised in 1987 as one of the events celebrating the 700th anniversary of the founding of the University of Heidelberg. The symposium was devoted to schizophrenia and was held near the university psychiatric clinic where Kraepelin first formulated many of the clinical concepts for which he is renowned. His name was invoked with reverence by most of the speakers and he figured prominently in the final summary of the papers by the octagenarian American psychologist, the late Joseph Zubin. Dr Zubin, who was something of a maverick, thanked the speakers for covering a wide spectrum of topics and then asked the solemn, predominately German audience what appeared to be a rhetorical question: "What would Kraepelin have thought of this work?" His next question, however, was more disconcerting than rhetorical. "Why don't we ask him?", he inquired, and proceeded to walk to the door, open it and call out "Come in, Emil". He then escorted an invisible figure – invisible at least to me – to a chair, and began a sort of ventriloquist's version of question and answer. The dialogue is reprinted in the published proceedings of the occasion in the form of a conversation between two characters, one called 'Interviewer', the other 'Emil' (Zubin, 1987). Here is a sample:

> *Emil:* I am very happy about the progress you report on the revival and standardization of diagnosis of schizophrenia . . . I wonder, however, why you call the method neo-Kraepelinian. It seems to me that you have returned to the original Kraepelin system.
>
> *Interviewer:* What led you to consider the importance of psychological tests as vulnerability markers?
>
> *Emil:* I was a devoted disciple of Wilhelm Wundt, the

> founder of modern experimental psychology and my original career ambition was to follow in his footsteps. One day Wundt noticed that I was wearing a new ring on my finger and enquired "Bist du verlobt?" I admitted that I was in love and was planning to get married. He looked at me with some astonishment and said "You know, Emil, I cannot guarantee you a chair as Professor of Philosophy, and I wonder whether you are not taking responsibilities which you may find difficult to carry out". Well, after this warning I felt compelled to take a post in the clinic when the next offer came. Thus not logic, but love, as it should, made the career decision for me.

Why recall this entertaining nonsense? Because of the response of an unsmiling senior German colleague whose opinion I requested when the session was mercifully over. He had clearly regarded the performance as neither entertaining nor nonsensical and he remarked with some feeling: "Herr Zubin should not have called him Emil". "What should he have called him?" I asked. "Professor Kraepelin", was the immediate reply. It brought to my mind two aphorisms that serve to introduce this lecture. The first is Nietzsche's saying that in the German-speaking world an ordinarius professor takes second place only to God. The second is the comment of the great French painter, Georges Braque, that every man has at least two faces, a view that he illustrated so well in his analytical Cubist portraits. It is the distinction between the two faces of Emil Kraepelin and Professor Kraepelin that constitutes my theme. An historical study may be undertaken either as a self-contained inquiry in its own right or with the aim of having the past illuminate the present. This one belongs to the second of these two categories.

Biographical note

First, a brief biographical note. Kraepelin was born in 1856, one of a tightly-knit bourgeois family in Neustrelitz in northern Germany. He was a diligent but not intellectually outstanding child with a keen interest in the natural world, especially botany. He contemplated a research career in biological science but eventually settled for a medical training, supplemented by a spell of experimental psychology in Wundt's laboratory which greatly influenced his subsequent outlook and research. On entering the field of psychiatry he quickly acquired a reputation for combining detailed clinical observation with an interest in classification. In 1887 he was appointed to a chair in the Baltic university of Dorpat, then moved to Heidelberg in 1891. He left Heidelberg for Munich in 1903, first to the university clinic and then to the Research Institute which he founded in 1916 and directed until the end of his career. There he confirmed his place as *primus inter pares* among the large group of outstanding German psychiatrists whose work laid the scientific foundations of the discipline as we know it today.

Research method and results

To evaluate the significance of Emil Kraepelin's long, productive life-time of clinical research and organisational activities in the field of mental disorder it is helpful first to establish the major contributions by which he is best known, namely his clinical method and its application to the field of classification. Here he was very much a man of his time. As Zilboorg has pointed out:

> "The history of German psychiatry of the nineteenth century is the history of psychiatric somatisation . . . in the middle of the century German psychiatry asserted the supremacy of the brain over any other structure and proceeded systematically to produce a psychiatry without a psychology" (Zilboorg, 1941).

When it became apparent that the physical substrate of many psychotic states was not readily identifiable, increasing attention was paid to the clinical delineation of the onset, course and outcome of these disorders. Kraepelin borrowed and elaborated Kahlbaum's notion of symptom-complexes but, unlike Kahlbaum, he posited the existence of disease-entities, with general paresis as the paradigm. Pending the discovery of the pathological basis of these disorders he directed his work towards the construction of a series of defined syndromes by means of careful observation of the clinical phenomena and their natural history. Studying many thousands of cases he attempted to delineate the form and content of the psychoses, abetted in this task by the virtual absence of effective treatments. In this endeavour he was less concerned with the mechanisms of disease than with the pattern of symptoms construed as biological facts. The work was conjoined to studies based principally on Wundt's objective psychology, with particular regard to laboratory experimentation. Subjective experience was minimised. Thus, in Kraepelin's opinion,

> "so-called psychic causes – unhappy love, business failure, overwork – are the product rather than the cause of the disease; they are merely the outward manifestation of a pre-existing condition; their effects depend for the most part on the subject's Anlage".

So much for 'life-events' and the whole concept of reactivity.

The evolution of Kraepelin's nosological thinking is best traced in the successive editions of his textbook, which grew from a brief conventional compendium of 385 pages in 1883 to a two-volume *Lehrbuch* of 2425 pages in the 9th edition of 1927. Changes were introduced in each edition, most radically in the 5th edition (1896), when the combined study of symptoms and outcome had come centre stage, and psychological speculation was virtually jettisoned. Traditionally accepted categories like secondary dementia, Wahnsinn and degeneration were discarded and a much simplified schema of disease-groupings was proposed, leading to the fertile suggestion of two major groups of functional mental disorders, the older notion of dementia praecox and the new rubric of manic–depressive psychosis. The latter appears first in the 6th (1899) edition of the textbook and is distinguished from the former by its clinical features and its relatively favourable outcome.

What did he actually do? Essentially, he recorded clinical and demographical information systematically on index-cards, treated the data numerically and subjected them to personal interpretation. He described his method of procedure as follows:

> "I went through all the available index cards relating to the different pathological forms I had to refer to. The index cards contained a very condensed résumé of all information on each case. Then, I excluded all those cases which seemed to be incomplete or questionable and began to group them under different aspects. The most similar cases were collected into larger or smaller groups and the clinical characteristics of these subtypes were defined more precisely. Thereby, the hereditary behaviour, proven external causes, the distribution of age, sex and profession were ascertained. Furthermore, genetic development, individual physical and mental symptoms, the course and outcome were taken into consideration. By examining the numbers, I gained criteria to judge whether the trial group arrangement was justified or should be altered" (Kraepelin, 1987).

Seemingly unaware of the problems associated with sampling, observer bias and statistical analysis, Kraepelin conceded that despite his emphasis on objectivity there was a strong subjective element in his procedure. He wrote:

> "I must admit that one could have serious objections to my form of procedure not to represent the progress of my clinical findings in scientific individual accounts accompanied by the other relating documents and observations but rather to present it as the current state of knowledge in successive editions of my textbook. My expressed opinions often changed over a few years and I could not be sure that my colleagues would agree with me, especially as I did not inform them of the observations that formed the basis of my opinions. With these extensive studies I simply could not spare the time to substantiate my opinions, and although I tried to encourage my pupils to do so they could, unfortunately, only fill the gap incompletely. I decided not to give those opinions which were generally accepted at the time, but I felt that I should write what seemed to me to be the nearest to the truth based on the recent scientific point of view."

Serious objections, indeed! Nowadays, such work would be viewed as a primitive exercise in clinical epidemiology, but with so many methodological flaws as to render it unacceptable to any editor of a peer-review journal. The weaknesses of the approach were not lost on his contemporaries. Wernicke, for example, advanced an altogether different schema of classification founded on cerebral localisation (Wernicke, 1906); Hoche pointed out the need to pay attention to symptom-complexes rather than to individual symptoms as the elements of clinical investigation (Hoche, 1991); Bumke took issue with the over-inclusiveness of the whole dementia praecox concept (Bumke, 1993). More recently, the whole binary division of the functional psychoses has been challenged radically by sophisticated empirical research (Crow, 1987). But perhaps the most searching assessment of Kraepelin's clinical work was made by Adolf Meyer who urged that much

> "safer clinical methods should be used than the largely prognostic considerations of Kraepelin and that dynamic formulations came closer to the needs of both physician and patient than the formal and peremptory dichotomy claimed by those who see but one of two fates, either manic-depressive disorder or dementia praecox" (Meyer, 1922).

Towards the end of his career Kraepelin acknowledged that his efforts to delineate two separate functional psychoses had failed, but he did not relinquish his belief in the existence of the disease-entities which, he asserted, would eventually be established (Kraepelin, 1974). To evaluate his claim Jablensky and his colleagues have recently re-examined the clinical data on the original counting-cards relating to all 721 patients admitted to the Munich University Psychiatric Clinic in 1908, when Kraepelin himself supervised the diagnostic procedure. All the cards were assessed independently by two experienced clinicians: the information was rated by means of standardised diagnostic instruments and subjected to sophisticated statistical analysis. The analysis of the data on the 63 patients diagnosed originally as 'dementia praecox' and the 134 patients with 'manic depressive insanity' demonstrated some degree of concordance between the original diagnostic groups and current diagnostic concepts,

but the more significant findings ran counter to Kraepelin's expectations, for the clinical pictures proved to be more important than the longitudinal patterns of disease (Jablensky *et al*, 1993).

Clinical science

Kraepelin's credo is developed most clearly in his late paper, *Ends and means of psychiatric research* (Kraepelin, 1992*a*). Here, re-affirming the role of general paresis as his prototype, he declared his central objective to be a "search for unitary morbid processes" which, he states, "always arise from similar definite causes. Apart from certain clinical features often difficult to apprehend, the data for the recognition of such a process are chiefly the course and result, and, in certain groups, the post-mortem appearances". Ultimately, for him the final common path of all such research was an understanding of cerebral function and the relationship of dysfunction to mental symptoms.

> "For a final decision one must be guided by the upshot of the case and, in the event of death, by the finer post-mortem appearances of the brain; also, in certain circumstances, by the history of onset, but only in a minor degree by the details of the clinical picture. . . . What we require above all is a clear characterisation of the post-mortem appearances of the brain in as many morbid processes as possible."

Along with neurobiological study of the brain and the influences on it, especially endocrinological, went animal experiments and psychological research on man:

> "By the elaborate methods of experimental psychology we can obtain a more exact picture of the change produced in the mental life by natural processes of disease. So far as the patient is at all amenable to such experiment, we may be able to make out whether and in what degree the perception and understanding of external impressions, their retention in the memory, the rapidity of processes of thought, the content of ideas, the aptitude for improvement through practice, the susceptibility to fatigue, the release of voluntary impulses, the execution of simple movements, and the finer performances of speech and writing, are affected and altered by morbific influences."

To help investigate these phenomena Kraepelin included the study of the effects of drugs, and his work on 'pharmacopsychology' constitutes an early attempt to foreshadow an important aspect of psychopharmacological inquiry. He also acknowledged the need to study the key concept of personality in his approach to mental disorder, always emphasising objective inquiry into noxious influences on the life-cycle, e.g. genetic and developmental insults, injuries, toxins, degenerative change, infection, drugs and adverse environmental factors. In addition, he strongly advocated the sub-discipline of what he called 'comparative psychiatry' as a means of elucidating the causes of mental disorders and of determining the influences on their forms of presentation. In 1904 he visited the asylum of Buitenzorg in Java to examine the similarities and differences between European patients and those from an alien culture. And with the passage of time comparative psychiatry was to become more than a forerunner of the transcultural study of psychosis. It was to extend beyond institutional illness to the population at large:

> "The ultimate problem of comparative psychiatry is the determination of the influence of personal disposition or liability to insanity and on the forms that insanity assumes. Of prime importance in both these respects is the original mental make-up of the individual, his intellectual development, his temperamental disposition and the qualities of his will, which to some extent, however, can be altered by his conditions of life. For characterising the personality in all these aspects we must invoke the analytical and mensural resources of psychological experiment. This enables us, in some directions at any rate, to resolve our general impressions into clearly defined details. Least accessible by such means are the emotional processes, though even here, by examination of the various kinds of expressive movement, of speech and writing, and of involuntary expressions, as well as of the pulse, the blood-pressure and the respiration, there is some prospect of obtaining valuable results. Such investigations will help to provide a survey of the various modes of composition of healthy personalities. By so determining the range of normal variation, we shall obtain a standard for measuring morbid deviations – a standard that will be of value, not merely for pure science, but for many practical purposes, as for estimating school capacity, military fitness, business talent and responsibility. A first attempt in this direction is seen in the procedure devised by Binet and Simon for gauging the mental efficiency of children of different ages . . ."

In statements of this type Kraepelin shows himself to be aware of the need for a much broader research framework than that with which his name is usually associated.

Thus far his viewpoint could reasonably be viewed as a logical extension of his own clinical experience. His outlook, however, embraced a much wider spectrum of mental disease:

> "The effect of injuries apt to influence unfavourably the mental disposition of man expresses itself, as we may well understand, not exclusively, nor even perhaps most seriously in the occurrence of pronounced mental illness,

> but much rather in the numberless more or less shocking phenomena of everyday life in which the mental constitution of the members of the community is manifested. Important among these are suicide, crime, vagrancy and prostitution, the frequency and the motives for marriage, the tendency to produce and rear offspring, and the results of education in elementary and higher schools; to some extent military fitness, certain manifestations of political and religious life, migration from rural into towns, business enterprise, and much else . . .
>
> The investigation of such phenomena affords insight therefore into the metamorphoses of the popular mind. The study of such manifestations of the popular mind furnishes a means of recognising betimes and so perhaps of counteracting, untoward and dangerous changes in its behaviour.
>
> . . . A mass psychiatry, having at its disposal statistics in their widest scope, must provide the foundations of a science of public mental health – a preventive psychological medicine for combating all those mischiefs that we group under the head of mental degeneracy."

Nowadays this would be regarded as the province of psychiatric epidemiology. Kraepelin himself did not engage in epidemiological work along these lines, but the research programme at the Institute that he founded in the last decade of his life included biometrics and epidemiology along with neurobiology and physiological psychology to demonstrate the importance of a multidisciplinary approach for mental illness. This achievement was arguably his most durable contribution, as testified by the subsequent creation of similar institutions in other European and North American centres, and it underpins the verdict of Jablensky *et al* (1993), that

> "Kraepelin's approach to the study of mental disorders was essentially a natural scientist's approach of an astonishing breadth. He relied on objective observation but was fully aware of the problems of observer bias and reliability; he introduced the psychological and pharmacological experiment as well as statistics, in clinical research; maintained a keen interest in technological innovation; and regarded nosological groupings as working hypotheses in continual need of testing and reformulating."

This judgement has been widely endorsed, often without reservation, by Kraepelin's many admirers. The statement that "Modern psychiatry begins with Kraepelin" which appears in a weighty English textbook (Slater & Roth, 1969) accords with most contemporary opinion. It has received powerful support from many 'biological' psychiatrists worldwide; and it is explicitly acknowledged by the so-called neo-Kraepelinian movement in North America where it is embodied in the systems of classification developed in the 3rd and 4th editions of the Diagnostic and Statistical Manual.

The man and his outlook

This is the familiar professional face of Emil Kraepelin. It is, however, a one-sided picture. His other face belongs to the man whom my colleague at Heidelberg preferred to term Professor Kraepelin, a man whose contributions were rather different and have been much less publicised. They are of some interest both in their own right and for their wider implications but to put them in perspective demands a little more knowledge about the man and his background in time and place.

During his lifetime Kraepelin was well-known for his personal reserve and his distaste for any invasion of privacy. Contemporary accounts portray him as an energetic, determined, kindly man, with an unshakeable belief in his own capacity and in natural science, revered by his family and friends and respected by his opponents. He quotes with approval Heinroth's rules of professional conduct for the physician:

> ". . . he must possess good health and physical endurance . . . He must be fearless and not shun toil . . . His profession must interest him and take first place in his life; he must practice it with fervour and with love. He must be sincere, trustworthy and sympathetic . . . He must have the power to be firm as well as gentle . . . He must be not only a man of science and art but also a doctor in the broad sense of the word – one educated through study and skilled through practice. He must be neither a rank empiricist nor an idle speculator. He must adhere to the world of nature and live in the world of ideas. He must be guided by reason in his struggle against the absence of reason. He must be experienced in the ways of the world and know how to treat men as individuals. Finally, he must thoroughly understand from both the theoretical and the practical viewpoint the psychic methods of treatment of every expert, not just one therapeutic practice. He must have the capacity to experiment and to observe. If he is to advance the science of psychiatry, he must exhibit intelligence, not fanaticism; true genius is methodical but not mechanical" (Kraepelin, 1962).

While this may correspond to some sort of ideal of a psychiatric registrar or consultant, to me it exhibits a touch of what Coleridge, who knew and admired the German nation, regarded as its besetting fault – what he called nimiety or too-muchness. And it does not need speculation or psychological theorising to show that it is a misleadingly superficial picture which conceals the complex inner world emerging from Kraepelin's memoirs, his autobiography, his lesser-known writings and his poetry. These depict a restless, solitary spirit without a formal religious faith but with the quasi-mystical yearnings so often associated with German romanticism. His internal

conflicts are apparent. Not every self-professed atheist, for example, would admit that "I consider the dogma of Buddha to be the greatest religious philosophical achievement of the human intellect"; on the authority of his daughter, Frau Dr Schmidt-Kraepelin, we know that during the last year of his life he was preoccupied with Buddhist teachings and was planning to visit Buddhist shrines in India at the time of his death. Nor can the image of the detached natural scientist be readily reconciled with a long-standing identification with the prophet Moses who so gripped his imagination as to impel him to stand before the statue of Moses in the library of Congress in Washington, DC and remark: "I shall meet the fate of Moses. I too shall see the Promised Land from afar and then lay myself down and die". The inner tension between a love of order and a longing for unrestrained freedom constitutes a major theme of his published poems. While these are totally devoid of literary merit they are of some auto-biographical interest. Here, for example, it is a quotation from a poem entitled 'Freedom':

"The torment of his discord who can tell?
How brims life's chalice oft with gall before me!
And yet, my deepest nature loves it well,
This rebel's strife! Without it I abhor me".

But there was one lode-star in Professor Kraepelin's troubled firmament. "I have", he affirmed, "felt myself more or less lonely all through my life . . . I had, however, a strongly marked feeling of race and stock and also felt my inner independence as an essential trait of the German character. My whole heart belonged to my fatherland and I willingly flung away cool objectivity of judgement when it was a matter of defending German interests" (Brink & Jolliffe, 1932).

Germany and politics

To appreciate what he understood by the 'fatherland' and by 'German interests' calls for a brief reference to modern German history. Kraepelin came to maturity during the epoch which followed his country's victory in the Franco-Prussian war of 1870 and its subsequent unification. Under the chancellorship of Otto von Bismarck Germany rapidly became a mighty military power and a leading nation in every sphere of economic, material and intellectual activity. Great importance was attached to the natural sciences and their potential contribution to the Bismarckian state, which was originally conceived as a form of liberal autocracy. By the year 1900 it was possible for a German statesman to remark that Germany would be either the hammer or the anvil of the twentieth century, a metaphorical prediction of two world-wars and a death toll of some 50 million people.

Medicine shared in these expanding developments and psychiatry was a major beneficiary. In the course of one generation the foundations of academic and institutional psychiatry had been laid by the end of the nineteenth century. Kraepelin himself sketched its evolution in his book, *A Hundred Years of Psychiatry* (1962). By 1911 he calculated that some 500 institutions for the mentally ill had been constructed, and all German medical schools contained university departments of psychiatry. "We are", he commented, "in this respect superior to all other nations of the world".

And not only in this respect. In Germany for a whole generation the notion of superiority, of national and racial superiority, had been supported by attempts to apply the biological sciences to socio-political issues. The whole tangled story has been unravelled by Paul Weindling in his monograph, *Health, Race and German Politics between National Unification and Nazism, 1870–1945* (Weindling, 1989). From the 1880s onwards the academic medico-scientific community, led by its professoriate, was increasingly preoccupied with human genetics, eugenics, 'racial hygiene', theories of degeneration, and monism, and with the adoption of such measures as abortion, sterilisation, selective breeding and the prevention of alcohol consumption and venereal disease, all with the aim of improving racial purity. The physician, in Weindling's phrase, became "the hygienic Führer of the Volk". Psychiatrists played a major role in this movement and Kraepelin was prominent among them.

Just how far he was prepared to discard 'objectivity of judgement' in pursuit of his patriotic ideals emerges from the development of his medical and political work in the public domain. While still at Heidelberg he had formed the opinion that mental illnesses were above all social disorders and his views on the body politic (*Volkskorper*) are set out in his early paper on 'Crime as a Social Disease', in which he extrapolated from his clinical experience and attributed most criminal behaviour to what he called a "congenitally inferior predisposition" (Kraepelin, 1906). In contrast to the fatalistic determinism which characterised his view of mental illnesses as essentially degenerative disorders, his approach to mental hygiene was altogether more positive. Basing his stand on his extensive experience of institutional psychiatry, he expressed himself forcibly on the prevention of alcoholism and syphilis, two of the indisputable causes of severe psychosis. In 1895 he advocated total abstinence from alcohol and

thenceforward was a tireless, even a fanatical supporter of anti-alcohol campaigns.

On the outbreak of the First World War Kraepelin's nationalism became more intense and steadily grew as the outcome of the conflict became increasingly uncertain. Viewing venereal disease as a major threat to the health of the German army, he launched a personal campaign to establish a national screening programme which involved him in a tenacious but ultimately unsuccessful struggle with the Ministry of War. Frustrated by failure, he took up active politics. He joined the People's Committee for the Rapid Subjugation of England, a body dominated by right-wing members of the academic community. He helped to draw up the annexationist *Guidelines for Paths to Lasting Peace*. And he campaigned for the overthrow of the Chancellor and the introduction of a more authoritarian rule in Germany.

None of these projects came to fruition, as he admitted in a revealing poem:

> "Trusting in the wings of my will
> I swore to dispatch the misery of my people,
> To drive us through peril and danger
> And fulfil the promise of their prosperity.
> Arduous and long the journey. In bloody victories
> And with an ardent heart did I execute my mission
> To but one enemy was I to succumb:
> The thanklessness and delusion of my own people".

The defeat of Germany left him an embittered man who devoted his post-war years to building up the German Research Institute for Psychiatry, of which he wrote in 1921:

> "Of course our institute should be the home of vigorous science. But at the same time we never want to lose sight of the ultimate goal envisioned by our patrons: to serve the nation's health and to work toward healing the deep wounds which bitter fate has inflicted upon our fatherland" (Kraepelin, 1992*b*).

What Kraepelin failed to realise, however, was that his fatherland was already a thing of the past. His fatherland was Bismarck's Germany, based originally on a liberal authoritarianism allied to military power and material prosperity which Max Weber had scornfully dismissed as a short-term political episode. "What is truly German," said Weber, "is held together only by the German language and by the spiritual life which manifests itself in it . . . The political aspect is merely one dimension, and an unhappy one at that, a history that proceeds from one catastrophe to another". Kraepelin preferred Bismarck. In a paper on Bismarck's personality and achievements, written in 1920, he expressed unbounded admiration of the Iron Chancellor without appearing to appreciate that the dismissal of Bismarck and the ascendancy of Wilhelm II had heralded a new, aggressive chauvinism which was to be exacerbated by the defeat in World War I (Kraepelin, 1921). In company with most like-minded members of the educated classes whose outlook had been formed in the hey-day of Bismarck's era, Kraepelin interpreted the disastrous political and military consequences of pan-Germanic nationalism as the result of an unfortunate disease of the body politic which called for prompt treatment and rehabilitation. He was, in effect, assuming the role of a psycho-hygienic Führer, applying his own brand of biologically-based medical expertise to the political and social problems of the day. And in 1919 he made his views explicit in a paper entitled 'Psychiatric observations on contemporary issues', in which he declared himself to be "a psychiatrist who takes a stand on contemporary issues, reporting from the perspective of his professional experience" (Kraepelin, 1992). A few extracts illustrate his conclusions:

On war:

> ". . . there can be absolutely no talk whatsoever of a morbid disorder. The drive of self-assertion is the primal and most powerful force behind all individual and group action".

On the German emperor, William II:

> ". . . it is simply impossible in the case of William II to posit the existence of an acute mental disorder".

On sex-differences:

> "Based upon broad experience I believe we can view these apparently arbitrary upheavals of the will as the response of primal defence mechanisms to the dangers of life . . . In the case of the mature and emotionally well-anchored male, these antiquated defence mechanisms against overwhelming external pressures no longer have a role to play . . . it was the women who proved to be ill-prepared for the prolonged state of war and who tormented their sons and husbands at the front with their complaints and who at times breached the trust of those in the field".

On "individuals with distinctly hysterical traits":

> "among the leaders of current and past upheavals one also finds a surprising number of people who in one way or another fall outside the bounds of normality".

In this latter category he concludes "dreamers and poets, swindlers and Jews":

> "The active participation of the Jewish race in political upheavals has something to do with this [morbidity]. The frequency of psychopathic predisposition in Jews could have played a role, although it is their harping

criticism, their rhetorical and theatrical abilities, and their doggedness and determination which are most important".

On the causes of social unrest:

> "What struck the informed observer was the wholesale ignorance of the collective psyche . . . Experience with accident neurosis has shown that providing pensions to those unwilling to return to work breeds an artificial work-disability which under certain circumstances can result in lasting mental decrepitation . . . The government measures presume that humans by nature tend to perform their duties, to work hard and to commit themsevles to the common good. The development of every child teaches us that this conviction is false . . . we cannot escape the fact that the natural and self-evident drive behind all actions is selfishness and that in the case of popular rule this selfishness will seek its due with violent force as soon as the powers of the state designed to hold it in check are destroyed . . . It must be made absolutely clear that the stratification of human society is certainly far more the expression than the cause of the immeasurable inequality among humans. Accordingly, the emergence of classes of people would very much depend, if not for the individual then certainly for the succession of the lineages, on those abilities which come to be developed in them. And the proletariat would be chiefly a conglomeration of those countrymen whose ancestors could not, over the centuries, rise to the top . . . true popular rule is entirely impossible. Invariably the masses submit to individual leaders who by virtue of certain qualities have risen to the top. They are true leaders; those led by them are left with only the appearance of sovereignty. It is not they who decide, but rather the superior leaders who understand how to force the others to follow".

On future measures:

> "We will have to work systematically and employ all of our resources in the physical, mental and moral regeneration of our people. The essential framework has already been explicated numerous times during the course of the war, especially by doctors. Attention must be focused above all on the fight against all those influences threatening to destroy future generations, in particular hereditary degeneration and genetic influences resulting from alcohol and syphilis. Furthermore, the following will be necessary: the greater possible encouragement of early marriage, the fostering and strengthening of the joys of parenthood, the protection of the younger generation from the changes of physical, mental and moral neglect, the strengthening of the body, of the mind, and in particular of the will, by means of their regular and appropriate engagement."

This is not merely the language of pseudo-science. In its historical context it carries the disturbing political overtones of proto-fascism. It gives more sophisticated expression to the rhetoric being fed to the brown-shirted ruffians who were then congregating in the nearby Munich beer-cellars to form the nucleus of the National Socialist party, and at first sight it is difficult to reconcile with the objective outlook and independence of mind exhibited by Emil Kraepelin, the clinician and natural scientist. But Professor Kraepelin belonged to a different thought-collective, one which incorporated ideas and sentiments that led to an implacable opposition to the Weimar republic and which contributed to the demise of democratic government in 1932.

The historian A. J. P. Taylor has summarised the tragic outcome succinctly:

> "The defeat of Germany and the fall of the monarchy in 1918 threw the admirers of Bismarck into confusion. . . . The great majority of the Bismarckians, with the university professors at their head, remained faithful to the dead monarchy. . . . They still prized the Rechtstaat, the rule of law, but they supposed it would survive the overthrow of the republic. . . . The Bismarckians got their way. The republic was overthrown by Hitler in 1933. . . . Then the Bismarckians discovered to their horror that, while they had got everything they wanted, they had also lost everything that they prized. The Rechtstaat, the rule of law, had vanished. The Nazi barbarians ruled. . . . Once more, as in 1914, the respectable Germans of all classes tried to present the war (1939–1945) as one of defence, and they clung desperately to the hope that the Rechtstaat would be restored when the war was over" (Taylor, 1955).

Their hopes were to be sadly disappointed.

Implications and conclusion

Dying as he did in 1926, Kraepelin was spared involvement in these terrible events. We cannot know whether, like the overwhelming majority of German professors, he would have voted for Hitler in 1932. Or what he would have made of the version of his fatherland adopted by the Third Reich. Or how he would have responded to developments within his own Institute in the 1930s, when his close associate and successor – the psychiatric geneticist Ernst Rüdin – jointed the Nazi party and participated actively in the racial hygiene programme that was to lead to a policy of genocide and the nimiety of the gas chambers. Or if he could ever have accepted Fritz Stern's considered verdict that from 1933 to 1945 the German academic profession, with medicine and psychiatry in the vanguard, furnished "the most flagrant example of a *trahison des clercs* in the twentieth century" (Stern, 1986).

What general lessons can be learnt from this brief scrutiny of Kraepelin's two faces? I would suggest that there are two major conclusions of contemporary relevance, one negative and the other positive.

The first of these is simple. Kraepelin's reputation, derived from a partial knowledge of the man and his work, is iconic. Icons exist to be worshipped, but a touch of iconoclasm is a safer bet. Histographical research is making it clear that, with a handful of exceptions, the leading figures in the history of psychiatry exhibit far too much clay below the ankles. Kraepelin is one among many.

The second, more complex issue has to do with ethics. Sir Aubrey Lewis always insisted on posing the question: "how far can the psychiatrist keep his Weltanschauung, his general philosophy of life, apart from his scientific medical work?" (Lewis, 1991). He concluded:

> "Nobody in psychiatry can do without a philosophical background, but very often it is an implicit and not an explicit one. . . . This matter has received much less attention than it deserves. Philosophical influences, social influences, religious influences, ideological influences, all play their part in moulding the mental outlook of psychiatrists. We need to acknowledge and reckon with this when we are trying to establish a truly sound scientific discipline of psychiatry."

Kraepelin would have disagreed. He equated the true beginnings of his discipline with what he called "the victory of scientific observation over philosophical and moral meditation". The weaknesses of his position, however, were searchingly exposed by Karl Jaspers, a more profound German psychiatrist/philosopher, who pointed out that the supposedly atheoretical Kraepelinian system is replete with such implicit philosophical concepts as Kantian disease-entities, the cloudy notion of the 'will' and an idealistic version of the mind–brain nexus. And while acknowledging its heuristic value in providing testable biological hypotheses Jaspers observed that

> ". . . the biology of this so-called 'biological psychiatry' . . . expresses the drive of an idea, a philosophical tendency, which perhaps does not quite understand itself but as an object for scientific research it appears quite baseless. . . Science is wrongly identified with natural science . . . Natural science is indeed the groundwork of psychopathology and an essential element in it but the humanities are equally so and, with this, psychopathology does not become in any way less scientific but scientific in a different way" (Jaspers, 1963).

This critique raises the crucial question of precisely what philosophical position should be adopted by psychiatrists. That large topic goes far beyond my remit, but its shadow falls on the two faces of Professor Emil Kraepelin. Three contemporary observers have justly concluded that probably his greatest and longest-lasting influence lies in "the impetus that he gave to psychiatric research" (Hippius *et al*, 1987). It detracts in no way from his achievements as a clinical scientist to point out that his philosophical amblyopia, allied to the ineradicably chauvinistic elements in his outlook – formed in his youth and shared by many others as part of a national consciousness – resulted in a failure to demarcate the boundaries of his professional expertise and seriously distorted his judgement on the wider implications of his own contributions. He was guilty of what mediaeval scholastics termed *ignoratio elenchi* and modern logicians call category error. Taken as a whole his work illustrates not only the potential value but also the evident limitations of natural science, *Naturwissenschaft*, in the study of human behaviour. Both lessons are highly relevant to the theory and practice of psychological medicine today.

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Two faces of Emil Kraepelin.

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